Site Visiting the Seven Consortia in the Community-Based Public Health Initiative (CBPH): Reflections on Year Two

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Purpose of this Report

People often ask the Cluster Team "what we're finding out" by virtue of conducting week long site visits with the seven consortia in the Community-Based Public Health initiative. This report represents our attempt to answer that question. We are writing it primarily for consortium members and the W. K. Kellogg Foundation (Foundation), although we understand that it might be shared with others who are less familiar with the initiative.

We do not restate the purpose of the CBPH or its history here. For those who are new to the CBPH, and even for the current members, however, it probably bears repeating that the CBPH initiative is an experiment. Not an experiment in the research sense, with a uniform intervention, controlled variables, and precise measurements, but a broadly conceived effort at social and institutional change at the local level using a variety of new and semi-tested strategies.

In such an experiment, evaluators like ourselves need to clarify that what we are observing is an emerging process. We do not know where the consortia are going to "end up" or what they will discover along the way. Nor do we have all the answers about what is supposed to happen, or how it should occur. Nonetheless, we can observe this experiment from a special vantage point and comment on how the broad directions of the Foundation play out differently in different settings. The intent of this report is to briefly describe, and then to reflect on what we have seen and heard during this second round of annual site visits. We offer these comments to CBPH stakeholders and others engaged in similar efforts. Hopefully, this will encourage reflection and stimulate more questions. [Note: For a more comprehensive summary of the Cluster Evaluation findings, drawing upon data gathered from all four evaluation strategies (including indicators, surveys, and video documentary), see our upcoming 1994 Annual Report.]

The CBPH as an Experiment in Social and Institutional Change

What is the basic hypothesis being tested in the CBPH experiment? One way to answer this question (and we believe there are several) is this:

Can the three constituent groups involved in the CBPH -- the academic, public health practice, and community partners -- work together, collaboratively, to improve the practice and discipline of public health, as well as the capacity of communities to engage in public health problem-solving?

An underlying assumption is that, if the resources of all the partners are recognized, valued, and brought to the table within a common vision, then public health research, teaching, and practice can be positively transformed in community settings, public health agencies, and in academic institutions. And if the "business" in universities, health agencies, and communities can be positively transformed, then perhaps the health of the at-risk public can be improved.

What qualitative transformations in academia, public health practice, and the community are we talking about? What we have heard from the Foundation, and from members of CBPH consortia around the country, includes the following:

Public Health Practice

- Defining "public health" more broadly and interpeting it to encompass the holistic context in which discrete "problems" are embedded.
- A fundamental rethinking of "where the center of gravity is and where it should be" (i.e., recognizing the importance of community ownership and engagement in every core function).
- Better balancing of a service orientation with an empowerment orientation.
- Developing cultural sensitivity and skills; creating a more diverse work force.
- Re-organizing and redistributing services, resources, and decision-making.

Community

- Becoming proactive rather than reactive and dependent. Defining their own issues and problems; finding their "voice."
- Strategically identifying and securing resources and partners, building and maintaining relationships with institutions, networks, agencies, and key leaders.
- Overcoming the habit of looking at institutions only as "money" and seeing them as allies with worthy goals, constraints as well as resources.
- Building the skills to mobilize others; to organize, fund, and run programs.
- Building education and career pathways for young people so they can become players in the public health arena.

Academia

- Valuing experiential learning and action oriented research, and striking a new balance for these efforts along with more traditional classroom learning and research.
- Understanding that reform requires both the active engagement of faculty and staff in community issues, and the involvement of community people in aspects of curriculum, instruction, evaluation, and research.
- Examining the content of the discipline of public health, and including students, practitioners, and lay people in defining what knowledge is, which kinds of knowledge are important, and how knowledge can be gained, imparted, and applied in institutional and community settings.
- Realizing that "the health department" and "the community" are not one and the same; student practica in health departments do not necessarily buy real exposure to real problems, or engage students or faculty in grass-roots problem-solving.

What Progress is the CBPH Initiative Making?

If these are the general directions of change envisioned, what progress are CBPH consortia making?

From the beginning, the Cluster Evaluation has focused on the CBPH initiative as a whole rather than on individual consortia and their comparative strengths and weaknesses. We would be remiss in drawing the picture of CBPH, however, if we failed to say that consortia were in very different stages of development at the time of our visits (January - April, 1994). The disparity among consortia was greater than we expected.

For example, although things are changing "as we speak," a few consortia were doing quite well during this mid-point review. Although progress had not come easily or without challenge, these consortia seemed to have genuinely shared beliefs, strong communication linkages, and working relationships. Activities that were dependent upon, and enriched by collaboration were occurring. The operational and philosophical models undergirding their activities were carefully thought through and strong. Several other consortia had been successful in implementing many good activities, but had experienced significant divisions within their consortium and continued to struggle with unresolved questions concerning either their vision, their organizational structure, or both. In contrast, a few other consortia were struggling considerably with internal

conflicts and were at the point of disbanding, or departing significantly from their original proposal. These consortia had experienced great difficulty in establishing trust among partners, shared goals, buy-in from all constituencies, and a workable governance system. Virtually all groups reported that the most challenging hurdle in the first two years was that of developing a workable model of governance and a coherent agenda of shared activities.

In writing this report, we interpreted our task as looking across the initiative and reviewing the progress of the three constituent groups: Academe, Public Health Practice, and Community. For each constituency, we drew a hypothetical continuum of "system change," from high to low, to correspond to the shifts in direction described earlier. (The next several pages describe these shifts.). The specifics of the continua are perhaps a bit arbitrary; other people might identify different "levels," or sequence their order differently. We believe, however, that the continua suggest three general scales of potential change against which to gauge the progress of the CBPH initiative. While all the indicators of change on the scales are necessary, important, and good, those near the top (high) represent greater structural and philosophic change. In contrast, the indicators on the bottom represent "first steps" in change, or change that can occur at the perimeter of an organization or community without significant structural and philosophic change. We hypothesize that change "at the top" is more enduring than change "at the bottom," and that change at the top actually facilitates change at the bottom.

We present these scales below followed by comments on where we feel each constituency is in terms of systems change. We also comment on significant challenges or barriers for each group.

Public Health Practice

(HIGH)

- Development of a new public health mission
- Strong advocacy for big picture policy issues surrounding health (e.g., employment, education, environment, universal health coverage)
- Leadership in bringing policy-makers together to address health policy issues
- Reorganization of departments, inter-agency collaboration
- Interpreting "public health" broadly, as problems embedded in a context
- Emphasis on community capacity throughout core functions

- Involvement of community and academic partners in strategic planning for the health department
- Recruitment and retention of people of color and others from target communities
- Development of village (neighborhood) health workers and outreach staff
- Department-wide training of multicultural competencies
- Contracting services out to neighborhood health agencies,
- Working proactively with university interns
- Linking needs assessments to community assets and capacity building
- Developing a citizen board
- Sharing information, creating feedback loops with community and others

(LOW)

Findings: We found great disparity among CBPH health departments/partners on this scale. Several health departments were barely at the first step of sharing information with the community and appeared to be marginally involved with CBPH activities. A few agencies had been working vigorously at many, if not all, levels of the continuum for some time. The CBPH appears to have had demonstrable effect on some health departments, and virtually no effect on others.

Barriers: Public health agencies seem to have become a marginalized player in the health services arena. In some settings, health departments have (or perceive themselves to have) little clout in the power structure. Underfunded, buffeted about by system changes, some feel they are just "getting the left overs." The history of providing services has, for some, sapped energies for other core functions. Lack of vision appears to be a problem with some departments -- or perhaps it is the problem of "being on hold" until the outcome of federal health care legislation is known.

Community

(HIGH)

- Full power sharing partnerships with external institutions
- Ability to set priorities and control resources around public health, quality of life issues
- Positive, proactive ways of addressing institutional and environmental racism

- Mutually respective participation with academic and practice partners in research, education, service, outreach, assessment and planning, and other functions
- Development of community infrastructure; achieving the level of organizational capacity needed to be in power-sharing relationships with institutions
- Building career and education pathways for young people
- Expanded community economic development
- Building community base, mobilizing volunteers
- Leadership development
- Board development
- Training and individual skill development in communication, diversity, organization, planning, financial management, citizen politics
- Working with student interns in the community environment

(LOW)

Findings: Community partners varied widely in terms of type of organization or group, experience, depth of leadership, and degree of citizen representation. All were very involved and active in CBPH, but they were starting at very different places on this continuum. Some, with a history of organization and success behind them, were already controlling resources and influencing policy in their own settings. Others were just beginning to form relationships with institutions. Some had adopted institutional change as part of their mission; others were working more autonomously, without many linkages. A good many were just beginning to organize and were, therefore, in need of technical assistance related to building a community infrastructure and enhancing leadership and other capacities.

Barriers: For individual citizens and residents, the barriers include a variety of health, economic, and environmental problems. Barriers also include fear and distrust of professionals and others who live outside their neighborhood, as well as perceived racism and sexism. Oftentimes, the community members involved are women with limited financial resources and multiple demands on them to take responsibility for organizations and individuals in the community. The inadequacy of public education to prepare students to become proactive citizens is another constraint. Staff in community organizations face the challenge of competing for scarce resources, mobilizing the community, and "having to do

drug patrol, and get safety concerns taken care of, before you can call a meeting and organize and get people to come."

Academia

(HIGH)

- Mission change reflects epistemological change in the definition of public health knowledge, how that knowledge is gained and imparted
- Establishment of endowed chairs for researchers, educators, and practitioners of a community-based approach to public health
- Tenured appointments for faculty researching, teaching, and practicing a community-based approach
- Publications about community-based public health
- Recruitment and retention of faculty and students of color
- Research funding for community-based public health
- Involvement of faculty in public health practice program planning and service
- Curriculum planning with practice and community input
- Graduate level course revision; development of a core curriculum in community-based public health
- Senior faculty support and mentorship for community-based research, teaching, and service
- Coordination of internship experiences
- Revision of existing courses, development of new courses in public health
- Use of community and practice instructors
- Expansion of student practica and field experiences

(LOW)

Findings: As with public health departments, there were considerable differences among academic partners. While most were working at multiple levels within the continuum, a few had not yet taken the first couple of steps. The most prevalent activity was occurring in course revision and student field placements. Faculty were also providing technical assistance to community partners, and several consortia were embarking on collaborative research protocols and projects. Overall, the CBPH appears to have made a great impact on the faculty and students who have elected to participate in it.

Barriers: Until the pattern of federal funding changes, CBPH is fighting a tough battle in terms of changing the academic culture. Both faculty and administrators are concerned about continuing support for CBPH research, assistantships, and teaching efforts; junior faculty are especially anxious about putting their careers on the line in a direction that may not be sustained. Several schools face extremely difficult budget constraints. In general, the traditions of academic status, rewards, and peer pressure, as well as the entreprenurial ethos, limit more collaborative and community-based efforts.

What the Initiative is Teaching Us

In reflecting on the site visits, the Cluster Evaluation Team would like to offer the following summary comments. These comments build on conversations we had with many of you over the year.

1. Developing Linkages. Collaboration has been called an "unnatural act by non consenting adults" (Wandersman, 1993). It is very difficult to achieve, especially by diverse groups without a shared history. Factors influencing the degree to which collaboration can happen in the first year or two of a grant include the following:

   - prior relationships between partners (positive and negative)
   - quality and length of preparation for launching the partnership
   - the presence/absence and quality of facilitation that occurs during the formative year; attention to governance, decision-making, conflict resolution, and other processes
   - degree to which mutual self-interests can be identified, and the extent to which the partnership is based on advancing mutual interests, rather than simply obtaining and sharing dollars
   - degree to which the valued outcomes actually depend on interdependence and collaboration
   - depth of leadership; provisions for identifying and nurturing new leaders
   - members' commitment to earning trust and having faith, as opposed to getting and hoarding power

   While the word *collaboration* is frequently used, we believe it is less frequently practiced. We consider collaboration the most demanding kind of relationship

possible among partners because it calls for the sharing of risks, responsibilities, and rewards to enhance each other's capacities (Himmelman, 1992). (See "Types of Linkages Occurring in the CBPH, page 19.) Other valuable linkages between groups are entirely possible and appropriate for many circumstances, either "free standing" or as a prelude to collaboration. These include service and technical assistance, networking, coordinating activities, and cooperating. It is not realistic to assume groups can move automatically to a level of collaboration without having moved through the earlier levels. CBPH consortia are very different and operate under different conditions. Some environments are more favorable, or offer better windows of opportunity for change, than others. Therefore, it is not surprising to find consortia (and partners within consortia) operating at different levels, moving at different rates in their relationships with each other, and experiencing problems.

At the time of our visits, we felt most groups were at the early levels of: (1) structural development (building the operational models of their consortium); (2) providing technical assistance and service to each other, and (3) networking by exchanging information for mutual benefit. Some groups had clearly moved beyond structural development and technical assistance, and were putting at least some of their energies into coordinating activities and sharing resources. Some wonderful examples of collaboration were also apparent. When linkages were occurring, they had a tendency to happen only between two partners within a consortium, rarely among three or more. In some consortia, the paucity of linkages called in to question the rationale for the consortium, as the partnership did not appear essential for the activities to occur.

2. Handling Grant Funds. A prominent issue we heard about in many consortia concerned "money" -- how much the CBPH requires, which partners get what amounts of the budget, and who decides how money is spent. Sustainability of the CBPH was clearly on many people's minds.

   One observation to share is that consortia approached the task of budget allocation differently. The more successful groups appeared to have resolved budget issues early during the Leadership and Model Development (LMD) year and/or the awards process. Interestingly, only one consortium developed a budget around a consolidated work plan -- i.e., the money was not divided up among organizational partners on a percentage basis. Rather, it was allocated to a single entity that was then given the charge to develop and implement activities involving all partners.

Consortia which did "divide up the pie" typically allocated a greater proportion of funds to community partners than either academic or health practice partners. Percentages varied widely across the initiative. It's unclear to what degree a lack of funding for the institutional partners -- either for the consortium who funded a consolidated work plan, or the others who "divided up the pie" -- leads to barriers in institutional involvement. In some consortia, this was reported to be the case thus far.

Certainly, lack of resources is a constraint that all partners face. Still, it is difficult to tease out when lack of participation, or inability to fulfill objectives, is due to lack of money, or whether this constraint is symbolic of something else. Institutional partners who reported they were "moving in this [CBPH] direction anyway" acknowledged that the grant was a help, but they would probably have continued to change their organization, culture, or way of doing business without grant funds. For partners who were just starting to shift their way of thinking, the money seemed woefully inadequate for augmenting or supporting change. If, after two years, groups are still struggling with each other over money, we have to ask whether the practical needs are really the issue, or the power and validation which money symbolizes. Is money the source of conflict, or the symptom of lack of trust, lack of common philosophical vision, lack of commitment or readiness to be in an interdependent relationship with others? In such cases, it may be appropriate to figuratively take "money" off the bargaining table, and see what remaining issues divide the group.

3. Searching for the Appropriate Operational Model. Some consortia were still searching for the right operational model on which to structure their relationships and work activities. Some were aiming for a free-standing, non-profit 501(C)3 corporation with a strong central project director, board of directors, and advisors. Others had created a more innovative forum, looser in surface structure, but quite rich in communication and linkages. By trial and error, some consortia discovered the limits of consensus decision-making. Tensions between amount of time devoted to "process" vs. "product," "trust building" vs. "action taking" were common. The need to balance autonomy of independent partners or organizations with affiliation and commitment to a common agenda were also typical pressure points.

It is our belief that no single organizational model exists that consortia can simply adopt as a blueprint. This IS the task of CBPH consortia -- to build new models by which these constituent partners can work together towards common goals. Our site

visit experience suggests that "one size does not fit all;" the best model "solution" will emerge from the context of each consortium.

4. The Developmental View. Just as the Cluster Evaluation Team takes a developmental view on collaboration and types of linkages, we also take a developmental view on how constituent groups move through systems change mentioned earlier. For example, we noted that in several consortia, energy was going in to community development as a prelude to working on actual health issues. Supporting the formation of citizen groups, doing community organizing, and building leadership skills of community representatives was considered an important starting point in several consortia. Our experience confirms that without some infrastructure and developed skills, communities can't be in productive relationships with institutions, and participate in the CBPH as envisioned.

5. Diversity as an Asset. The challenge of working collaboratively in the CBPH includes the added challenge of working in highly diverse groups where roles are changing. CBPH members value inclusiveness and multiculturalism, but valuing it doesn't necessarily lead people to knowing how to do it. Some consortia sense there is enormous potential in the groups present around the table, yet have not been able to make best use of that potential. Lack of skilled leadership across constituencies within a consortium, or lack of skilled facilitation from outside, coupled with challenging group dynamics, have left some groups in conflict. It is our feeling that we all are still learning to understand how to work with people who are different from ourselves. We may not get it right the first, second, or even third try. We need to remain open to conflict and open to various kinds of support and assistance to work through communication, trust, and other issues.

Examples of Innovative Developments

The Cluster Evaluation Team has witnessed important new developments emerge during this year. Described below are a few examples. This selection is by no means comprehensive, nor is it meant to suggest that consortia are accomplishing progress in only one area. Rather, we've drawn out these examples to highlight important advances relative to four of our five guiding evaluation questions. These questions have to do with (1) model development, (2) community capacity building, (3) institutional and organizational change, and (4) policy change.

Model Development

- The Michigan Consortium has created an original governance structure which appears to successfully balance the need for autonomy of three separate teams with the positive value of affiliation to the larger consortium. Strong local governance occurs at team sites (Ann Arbor, Flint, and Detroit). A Collaborating Group of about 20 members from the three teams serves the teams, but is not a governing body in the traditional sense. For example, it is not incorporated and has no plans to become so. It has no designated leadership or officers (the meeting locations rotate and are chaired by the host team), no by-laws, and no formal reporting or accountability procedures. In this group members share ideas, approaches, and develop linkages; disagreements are aired. Decisions are made through a modified consensus approach "which we've never really defined." Our sense, however, was that the Collaborating Group avoids micro-managing the teams and is selective about which decisions have to be addressed at the consortium level.

  Such seeming informality belies the very rich ethos of communication and power-sharing which is built into the model. Various cross-cutting groups have been set up within the Collaborating Group to address issues such as evaluation, research, data and communication, and policy. Each of these groups draws members from health practice, academe, and community, and from the different teams (Ann Arbor, Flint, and Detroit). The concept of cross-representation of teams, and cross-representation of the three constituent partners, is replicated at the *team* level, and also in *sub committees* which the teams set up. Thus, the structure of the Consortium encourages frequent communication and interaction between all parties. In discussing the structure, one member felt that it "forces decision making to include a lot of people ... it forces us to continually dialogue and communicate." Another person said, "everyone has some ownership at some level." This is an example of how an operational model can support an underlying conceptual model of systems change using a community development approach.

- North Carolina provides another example of a successful governance structure. This Consortium operationalized its governance structure at two levels: 1) a formal Steering committee that guides the overall mission of the Consortium, and 2) a coalition level that addresses local community health issues and problems. These two levels function interdependently, but actually have separate roles and functions. The

four county coalitions (geographically separate and politically unique) link academic, health practice, and community partners at the local level to address specific community health problems, and build community capacity in the process. These same partners are linked at the Steering Communittee (where all coalitions are represented), where very different issues are addressed, such as Consortium sustainability, policy considerations, facilitation of linkages between the coalitions, and the promotion of a community-based public health approach in larger political arenas (e.g., state and national levels). More traditionally structured than Michigan, with formal officers, rotating leadership, and centralized reporting mechanisms, North Carolina has turned a potential management challenge (i.e., size, geographic spread, and diversity of coalitions) into a notable asset.

A related contribution by this Consortium is the theoretical base guiding its structure and work, which is provided by the social change model of public health practice. This model aims at improving community competence as a means to improving health outcomes. As noted previously, promoting community competence is a common theme across all four coalitions as they pursue community organizational and leadership development strategies. As the governance structure reflects the theoretical base of the social change model, the operational model of the North Carolina Consortium appears to be strengthened.

Community Capacity Building

- Youth activities is a strong focus in the Washington Consortium. From the beginning of the CBPH Leadership and Model Development year, the Lummi Indian community project has contributed especially to our understanding of how the traditions of a culture can be revitalized and used to guide programs aimed to strengthen the minds, bodies, and spirit of young people. The revival of canoe pulling was chosen as the vehical for recentering young people in tribal values and wellness. In this last year, fitness testing, in preparation for training in canoe pulling, took place for young men and women. Other planned activities included canoe repair, construction of a canoe shed, paddle-carving, a health fair, and workshops in cultural and health education. The focus on youth extends to a support program for students attending colleges and universities. At the Rainier and Garfield communities in Seattle (two communities who joined the Consortium a bit later in the process), the focus on youth has included student scholarships, health career fairs, and mentoring

programs for students in need of remedial education. This is an example of how a consortium can operationalize the meaning of "public health" by focusing on the capacity of young people to be healthy and contribute to the wellness of their community.

- MPH graduate students from Emory University, a Georgia Consortium partner, piloted an interesting mentorship/summer internship program (funded by the Coca Cola company) for teenagers in CBPH target communities. Four graduate students spent the summer helping high school interns develop various projects with and for their peers in low-income housing projects and neighborhoods. Project content varied from self-esteen and violence prevention to asthma and smoking cessation. These interventions were evaluated, typically with pre- and post-assessments of knowledge, attitudes, and behaviors. Part of the mentorship role included side trips to area colleges and universities and discussion of health careers. For two community teens, participation in the internship led to paid positions with Fulton County Health Department. Graduate students serving as mentors expressed satisfaction in seeing their mentees develop confidence and leadership skills in working on a public health issue in their own community. This is an example of how a single project can fulfill multiple CBPH goals: experiential and applied learning for graduate students; career mentoring and personal development for teenage community interns; and health education for young community residents.

- Across the CBPH initiative, we have also seen some important common strategies emerge which have the potential to build community and institutional capacity. One is the training of indigenous health workers (also called village health workers, community or neighborhood health workers). The second is in the use of mini-grants (or incentive grants) to support productivity and stimulate ownership by various partners. Both strategies show significant promise in several consortia.

Institutional Change

- The curriculum reform movement underway at the Johns Hopkins University, a Maryland Consortium partner, is worth watching. In the School of Public Health and Hygiene, the Faculty Agency Forum's Public Health Competencies have been tailored for a community-based approach. These competencies are being used to guide student assessment and program evaluation, as well as curriculum revision and course

instruction. Maryland is also demonstrating, in community sites such as the Heart, Body, and Soul Health Promotion Centers in East Baltimore, and Health Care for the Homeless in downtown Baltimore, an excellent integration of research, teaching, and service in neighborhood settings. In the Health Promotion sites, neighborhood health workers are trained by Hopkins faculty, hospital staff, and Baltimore Health Department staff to perform risk assessments, referrals, screening, and other services for neighborhood residents. Hopkins' students carry out various internships and field placements at the centers, and research is conducted on health status indicators. At Health Care for the Homeless, courses are co-taught on site with practitioners and student interns gain practical experience. The potential for integrating curriculum revision, with applied learning and research at these (and other) community sites, appears to be most promising and exciting.

- An example of a new center emerging as a result of the CBPH is the Community Health Academy sponsored by the California Consortium. Based (both physically and spiritually) in the heart of Oakland's multi-ethnic Fruitvale neighborhood, the Academy is the joint product of a county health agency and university school of public health partnering with community representatives from four ethnic groups from eleven different neighborhood organizations. The Academy has three main goal areas; for each area, a task force was created to develop and implement an agenda to meet that goal. The goal area which has been worked on the most to date involves curriculum development and training. Two curricula have been developed: a multicultural curriculum for health care professionals, students, faculty, and staff; and a health worker training for community health workers. Academy task forces have also begun planning the second and third goal areas, which are in child care and health campaigns. The Community Health Academy represents an example of partners channeling all CBPH funds through a single vehicle, built specifically to carry out the shared goals of the partners. More than any other approach, this structural model suggests a departure from partners simply continuing what they were doing separately with previous projects and previous funding.

Policy Change

- The Massachusetts Consortiums approach to policy change is worth noting because it links the need to educate people (e.g., students, professionals, lay persons in the community) about policy making and health policy issues with the task of organizing constituencies and

connecting them to key leaders. Thus, several things are happening simultaneously in this approach, which is as much about preparing groups to affect policy as it is about identifying actual policies.

A new course, "Community and Public Health Policy," was designed and introduced in the School of Public Health's spring (1994) program. A Public Policy Forum is planned for September, the goal of which is to "effect changes in local, state, and national policies . . . by increasing . . . professional and community residents' understanding of, and involvement in, public policy and its processes." Open to CBPH members, students, and others, the forum was identified as an appropriate time to orient new Advisory Board members. Several members from the Consortium sit on the state's Local Health 2000 task force, which was created by the Public Health Commissioner, to review "changes in the structure, responsibilities, and resources of local health boards," and to "develop a work plan and an adaptable set of core public health functions for local health boards statewide." Most interesting is the potential influence of the Massachusetts Association of Health Boards (a CBPH partner), which is uniquely positioned both to: (a) research policy questions (with the help of School of Public Health faculty and students); and (b) educate and inform local board of heath members about impending legislation and other policy questions.

Implications and Recommendations

We end this report by turning our attention to the coming year and providing a few recommendations and predictions -- something like the Cluster Evaluation Team's version of the Farmer's Almanac (hopefully a little more accurate).

1. Get Closure on Those Models! Now is the time for consortia to settle whatever remaining problems they have with their operational or philosophical models and get on with the business of delivering an agreed upon agenda. While many stages of consortium development are understandable and defensible, the more stable consortia in coming years (we predict) will be those with a common ethos or philosophy to guide their structure and activities. Part of the philosophical base that may be lacking in some consortia is a shared understanding of what "systems change" actually means in the three contexts of academe, practice, and community. This report includes some possible systems change indicators for your consideration, as seen in the three scales introduced earlier on pages 4-6. For consortia that need to clarify their models,

tailoring these scales for your own consortium may be helpful, and lead to a discussion of how to focus your energy in the coming year.

2. Support Local Evaluation. Local program evaluation is still underutilized in some settings. In four of the seven consortia, evaluators have well laid plans and good communication with key consortium partners. In three consortia, internal politics appear to be making it difficult for evaluators to proceed with consortium-level evaluation. Generally speaking, the local evaluations are becoming more collaborative (i.e., directed with stakeholder involvement and linked to project management and planning). The evaluation process will have to continue to take root, however, if evaluators are to produce useful findings for consortia in time to look for new external sources of funding. Evaluation is everyone's business -- not just the evaluators. Consortia which are most successful in securing new funds will be those with good evaluation plans and products -- not just those with good activities and dedicated members.

3. Support Public Health Practice. As national health care policies, practices, and funding patterns are transformed, all partners need to become more knowledgeable and concerned about the future of public health agencies, and to assist their health practice partner (as appropriate) in clarifying their mission and roles . All partners need to recognize that they can significantly contribute to this discussion by helping to problem-solve current dilemmas and clarify directions. We believe that the most viable consortia will be those whose public health agencies are engaged in CBPH and see their involvement in CBPH as instrumental for their reform.

4. Nurture CBPH Leaders. All consortia will have to give serious consideration to leadership identification, development, and transitions. Turnover of the veteran CBPH leaders from the LMD era is to be expected in an initiative like this, which often pushes individuals to burn-out. New leaders in all three settings need to be identified and supported.

5. Explore Foundation Clout. The Kellogg Foundation has an opportunity to play a special role in raising the status of community-based scholarship in order to support change in the academic culture. Among such opportunities are creating internationally prestigious fellowships and prizes for scholarly achievement and

community service. This will help faculty move ahead on community-based public health projects with with greater confidence.

Concluding Remarks

The third year of the CBPH appears to us to be a critical year. Consortia will need to demonstrate viable plans, functional relationships, and tangible progress in their work in the coming year if they are to maintain the involvement of their members and the attention of their broader communities and CEOs. Can academic, public health practice, and community partners work together to improve the practice and discipline of public health, as well as the capacity of communities to engage in public health problem-solving? Can they maintain new operational models which accommodate diversity, balance autonomy with affiliation, and provide for shared leadership? Can they overcome the challenges of collaboration and sustainability? These are some of the questions that we will explore with you in our visits next year.

In closing, let us say again that we find site-visiting to be a challenge, a pleasure, and an opportunity for learning. Let us know how we can do a better job of understanding and assessing your important work.

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Types of Linkages Occuring in the CBPH

1. **Structural**

   Working together to create and maintain the consortium.

   Examples: Work on mission statements, goals, budgeting, staffing, bylaws, committees, communications, publicity.

2. **Service and Assistance**

   One partner providing service or assistance to another.

   Examples: Technical assistance, training, outreach.

3. **Networking**

   Exchanging information for mutual benefit.

   Examples: Resource directories, forums, disseminating reports or data, meetings, conferences.

4. **Coordinating**

   Exchanging information and altering activities for mutual benefit and to achieve a common purpose.

   Examples: Internships, clinical faculty appointments, cross representation on academic, agency ,and CBO boards/committees.

5. **Cooperating**

   Exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose.

   Examples: Joint training of village helpers, joint programming, collaborative research.

6. **Collaboration**

   Exchanging information, altering activities, sharing resources, and enhancing each other's capacity, for mutual benefit and to achieve a common purpose, by sharing risks, responsibilities, and rewards.

   Examples: Creation of multi-purpose centers, curricula, joint degree programs,"think tanks."

CBPH Cluster Evaluation. Based on a framework of collaboration proposed by A. Himmelman and a content review of 1993 CBPH Annual Reports.